House of Representatives

General Assembly

File No. 211

February Session, 2014

Substitute House Bill No. 5378

House of Representatives, March 31, 2014

The Committee on Program Review and Investigations reported through REP. MUSHINSKY of the 85th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING MEDICAID-FUNDED EMERGENCY DEPARTMENT VISITS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 17b-261m of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) The Commissioner of Social Services may contract with one or more administrative services organizations to provide care coordination, utilization management, disease management, customer service and review of grievances for recipients of assistance under Medicaid and HUSKY Plan, Parts A and B. Such organization may also provide network management, credentialing of providers, monitoring of copayments and premiums and other services as required by the commissioner. Subject to approval by applicable federal authority, the

Department of Social Services shall utilize the contracted organization's provider network and billing systems in the administration of the program. In order to implement the provisions of this section, the commissioner may establish rates of payment to providers of medical services under this section if the establishment of such rates is required to ensure that any contract entered into with an administrative services organization pursuant to this section is cost neutral to such providers in the aggregate and ensures patient access. Utilization may be a factor in determining cost neutrality.

(b) Any contract entered into with an administrative services organization, pursuant to subsection (a) of this section, shall include a provision to reduce inappropriate use of hospital emergency department services, which may include a cost-sharing requirement. Such provision [may include] shall require intensive case management services, [and a cost-sharing requirement.] including, but not limited to: (1) The identification by the administrative services organization of hospital emergency departments which may benefit from intensive case management based on the number of Medicaid clients who are frequent users of such emergency departments; (2) the creation of regional intensive case management teams to work with emergency department doctors to (A) identify Medicaid clients who would benefit from intensive case management, (B) create care plans for such Medicaid clients, and (C) monitor progress of such Medicaid clients; and (3) the assignment of at least one staff member from a regional intensive case management team to participating hospital emergency departments during hours when Medicaid clients who are frequent users visit the most and emergency department use is at its highest. For purposes of this section and sections 17a-476 and 17a-22f, as amended by this act, "frequent users" means a Medicaid client with ten or more annual visits to a hospital emergency department.

(c) The commissioner shall ensure that any contracts entered into with an administrative services organization include a provision requiring such administrative services organization to (1) conduct assessments of primary care doctors and specialists to determine

patient ease of access to services, including, but not limited to, the wait times for appointments and whether the provider is accepting new Medicaid clients, and (2) perform outreach to Medicaid clients to (A) inform them of the advantages of receiving care from a primary care provider, (B) help to connect such clients with primary care providers soon after they are enrolled in Medicaid, and (C) for frequent users of emergency departments, help to arrange visits by Medicaid clients with primary care providers not later than fourteen days after such clients are treated at an emergency department.

(d) The Commissioner of Social Services shall require an administrative services organization with access to complete client claim adjudicated history to analyze and annually report, not later than February first, to the Department of Social Services and the Council on Medical Assistance Program Oversight, on Medicaid clients' use of hospital emergency departments. The report shall include, but not be limited to: (1) A breakdown of the number of unduplicated clients visiting an emergency department, and (2) for such clients with ten or more annual visits to any hospital, (A) the number of visits categorized into specific ranges as determined by the Department of Social Services, (B) the time and day of the visit, (C) the reason for the visit, (D) whether hospital records indicate the client has a primary care provider, (E) whether the client had an appointment with a community provider not later than fourteen days after the date of the hospital emergency department visit, and (F) the cost of the visit to the hospital and to the state Medicaid program. The Department of Social Services shall monitor its reporting requirements for administrative services organizations to ensure all contractually obligated reports, including any emergency department provider analysis reports, are completed and disseminated as required by contract.

(e) The Commissioner of Social Services shall use the report required pursuant to subsection (d) of this section to monitor the performance of an administrative services organization. Performance measures monitored by the commissioner shall include, but not be

limited to, whether the administrative services organization helps to arrange visits by Medicaid clients who are frequent users of emergency departments to primary care providers not later than fourteen days after treatment at an emergency department.

Sec. 2. (NEW) (*Effective July 1, 2014*) Not later than January 1, 2015, the Commissioner of Social Services shall require that state-issued Medicaid benefits cards contain the name and contact information for a Medicaid client's primary care provider, if such client has chosen a primary care provider.

Sec. 3. Section 17a-476 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) Any general hospital, municipality or nonprofit organization in Connecticut may apply to the Department of Mental Health and Addiction Services for funds to establish, expand or maintain psychiatric or mental health services. The application for funds shall be submitted on forms provided by the Department of Mental Health and Addiction Services, and shall be accompanied by (1) a definition of the towns and areas to be served; (2) a plan by means of which the applicant proposes to coordinate its activities with those of other local agencies presently supplying mental health services or contributing in any way to the mental health of the area; (3) a description of the services to be provided, and the methods through which these services will be provided; and (4) indication of the methods that will be employed to effect a balance in the use of state and local resources so as to foster local initiative, responsibility and participation. In accordance with subdivision (4) of section 17a-480 and subdivisions (1) and (2) of subsection (a) of section 17a-484, the regional mental health board shall review each such application with the Department of Mental Health and Addiction Services and make recommendations to the department with respect to each such application.

(b) Upon receipt of the application with the recommendations of the regional mental health board and approval by the Department of Mental Health and Addiction Services, the department shall grant such

funds by way of a contract or grant-in-aid within the appropriation for any annual fiscal year. No funds authorized by this section shall be used for the construction or renovation of buildings.

(c) The Commissioner of Mental Health and Addiction Services shall require an administrative services organization with which it contracts to manage mental and behavioral health services to provide intensive case management. Such intensive case management shall include, but not be limited to: (1) The identification by the administrative services organization of hospital emergency departments which may benefit from intensive case management based on the number of Medicaid clients who are frequent users of such emergency departments; (2) the creation of regional intensive case management teams to work with emergency department doctors to (A) identify Medicaid clients who would benefit from intensive case management, (B) create care plans for such Medicaid clients, and (C) monitor progress of such Medicaid clients; and (3) the assignment of at least one staff member from a regional intensive case management team to participating hospital emergency departments during hours when Medicaid clients who are frequent users visit the most and when emergency department use is at its highest.

[(c)**]** (d) The Commissioner of Mental Health and Addiction Services may adopt regulations, in accordance with the provisions of chapter 54, concerning minimum standards for eligibility to receive said state contracted funds and any grants-in-aid. Any such funds or grants-in-aid made by the Department of Mental Health and Addiction Services for psychiatric or mental health services shall be made directly to the agency submitting the application and providing such service or services.

Sec. 4. Section 17a-22f of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) The Commissioner of Social Services may, with regard to the provision of behavioral health services provided pursuant to a state

plan under Title XIX or Title XXI of the Social Security Act: (1) Contract with one or more administrative services organizations to provide clinical management, intensive case management, provider network development and other administrative services; (2) delegate responsibility to the Department of Children and Families for the clinical management portion of such administrative contract or contracts that pertain to HUSKY Plan Parts A and B, and other children, adolescents and families served by the Department of Children and Families; and (3) delegate responsibility to the Department of Mental Health and Addiction Services for the clinical management portion of such administrative contract or contracts that pertain to Medicaid recipients who are not enrolled in HUSKY Plan Part A.

(b) For purposes of this section, the term "clinical management" describes the process of evaluating and determining the appropriateness of the utilization of behavioral health services and providing assistance to clinicians or beneficiaries to ensure appropriate use of resources and may include, but is not limited to, authorization, concurrent and retrospective review, discharge review, quality management, provider certification and provider performance enhancement. The Commissioners of Social Services, Children and Families, and Mental Health and Addiction Services shall jointly develop clinical management policies and procedures. **[**The Department of Social Services may implement policies and procedures necessary to carry out the purposes of this section, including any necessary changes to existing behavioral health policies and procedures concerning utilization management, while in the process of adopting such policies and procedures in regulation form, provided the Commissioner of Social Services publishes notice of intention to adopt the regulations in the Connecticut Law Journal within twenty days of implementing such policies and procedures. Policies and procedures implemented pursuant to this subsection shall be valid until the time such regulations are adopted.**]**

(c) The Commissioners of Social Services, Children and Families,

and Mental Health and Addiction Services shall require that administrative services organizations managing behavioral health services for Medicaid clients develop intensive case management that includes, but is not limited to: (1) The identification by the administrative services organization of hospital emergency departments which may benefit from intensive case management based on the number of Medicaid clients who are frequent users of such emergency departments; (2) the creation of regional intensive case management teams to work with emergency department doctors to (A) identify Medicaid clients who would benefit from intensive case management, (B) create care plans for such Medicaid clients, and (C) monitor progress of such Medicaid clients; and (3) the assignment of at least one staff member from a regional intensive case management team to participating hospital emergency departments during hours when Medicaid clients who are frequent users visit the most and when emergency department use is at its highest.

(d) The Commissioners of Social Services, Children and Families, and Mental Health and Addiction Services shall ensure that any contracts entered into with an administrative services organization require such organization to (1) conduct assessments of behavioral health providers and specialists to determine patient ease of access to services, including, but not limited to, the wait times for appointments and whether the provider is accepting new Medicaid clients; and (2) perform outreach to Medicaid clients to (A) inform them of the advantages of receiving care from a behavioral health provider, (B) help to connect such clients with behavioral health providers soon after they are enrolled in Medicaid, and (C) for frequent users of emergency departments, help to arrange visits by Medicaid clients with behavioral health providers not later than fourteen days after such clients are treated at an emergency department.

(e) The Commissioners of Social Services, Children and Families, and Mental Health and Addiction Services, in consultation with the Secretary of the Office of Policy and Management, shall ensure that all expenditures for intensive case management eligible for Medicaid

reimbursement are submitted to the Centers for Medicare and Medicaid Services.

(f) The Department of Social Services may implement policies and procedures necessary to carry out the purposes of this section, including any necessary changes to procedures relating to the provision of behavioral health services and utilization management, while in the process of adopting such policies and procedures in regulation form, provided the Commissioner of Social Services publishes notice of intention to adopt the regulations in accordance with the provisions of section 17b-10 not later than twenty days after implementing such policies and procedures. Policies and procedures implemented pursuant to this subsection shall be valid until the time such regulations are adopted.

Sec. 5. Section 17b-241a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

Notwithstanding any provision of the general statutes, **[**and the regulations of Connecticut state agencies,**]** the Commissioner of Social Services may reimburse the Department of Mental Health and Addiction Services for targeted case management services that it provides to its target population, which, for purposes of this section, shall include individuals with severe and persistent psychiatric illness and individuals with persistent substance dependence. The Commissioners of Social Services and Mental Health and Addiction Services, in consultation with the Secretary of the Office of Policy and Management, shall ensure that all expenditures for intensive case management eligible for Medicaid reimbursement are submitted to the Centers for Medicare and Medicaid Services.

Sec. 6. Section 17b-245c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) **[**(1)**]** As used in this section: **[**, "telemedicine"**]**

(1) "Telemedicine" means the use of interactive audio, interactive

video or interactive data communication in the delivery of medical advice, diagnosis, care or treatment, and includes the types of services described in subsection (d) of section 20-9 and 42 CFR 410.78(a)(3). "Telemedicine" does not include the use of facsimile or audio-only telephone.

(2) "Telehealth" or "telemonitoring" means the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance. Telehealth or telemonitoring includes technologies such as (A) telephones, (B) facsimile machines, (C) electronic mail systems, and (D) remote patient monitoring devices used to collect and transmit patient data for monitoring and interpretation.

[(2)**]** (3) "Clinically appropriate" means care that is (A) provided in a timely manner and meets professionally recognized standards of acceptable medical care, **[**;**]** (B) delivered in the appropriate medical setting, **[**;**]** and (C) the least costly of multiple, equally effective alternative treatments or diagnostic modalities.

(b) **[**The**]** Not later than January 1, 2015, the Commissioner of Social Services **[**may**]** shall establish a demonstration project to offer telemedicine, telehealth or both as **[**a**]** Medicaid-covered **[**service**]** services at federally qualified community health centers. Under the demonstration project, in-person contact between a health care provider and a patient shall not be required for health care services delivered by telemedicine or telehealth that otherwise would be eligible for reimbursement under the state Medicaid plan program, to the extent permitted by federal law and where deemed clinically appropriate.

(c) The Commissioner of Social Services may establish rates for cost reimbursement for telemedicine and telehealth services provided to Medicaid recipients under the demonstration project. The commissioner shall consider, to the extent applicable, reductions in travel costs by health care providers and patients to deliver or to access

health care services and such other factors as the Commissioner of Social Services deems relevant.

(d) The Commissioner of Social Services may apply, if necessary, to the federal government for an amendment to the state Medicaid plan to establish the demonstration project.

(e) The transmission, storage and dissemination of data and records related to telemedicine and telehealth services provided under the demonstration project shall be in accordance with federal and state law and regulations concerning the privacy, security, confidentiality and safeguarding of individually identifiable information.

(f) **[**The**]** Not later than July 1, 2015, the commissioner shall submit a report, in accordance with section 11-4a, on any demonstration project established pursuant to this section to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and human services. The report shall concern the services offered**,** **[**and**]** the cost-effectiveness of the program and whether it should be extended to other areas of the state.

Sec. 7. Section 17b-292 of the general statutes is amended by adding subsection (m) as follows (*Effective July 1, 2014*):

(NEW) (m) A child who has been determined to be eligible for benefits under either the HUSKY Plan, Part A or Part B shall remain eligible for such plan for a period of not less than twelve months from such child's determination of eligibility unless the child attains nineteen years of age or is no longer a resident of the state.

Sec. 8. Subsection (f) of section 17b-261 of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(f) To the extent permitted by federal law, Medicaid eligibility shall be extended for one year to a family that becomes ineligible for medical assistance under Section 1931 of the Social Security Act due to income from employment by one of its members who is a caretaker

relative or due to receipt of child support income. A family receiving extended benefits on July 1, 2005, shall receive the balance of such extended benefits, provided no such family shall receive more than twelve additional months of such benefits. On and after July 1, 2014, the Commissioner of Social Services shall seek federal approval for a continuous eligibility period of twelve months for an adult who has been determined eligible for the Medicaid program.

Sec. 9. Section 17b-261c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

In no event shall an individual eligible for medical assistance under section 17b-261, as amended by this act, be guaranteed eligibility for such assistance for **[**six**]** more than twelve consecutive months without regard to changes in certain circumstances that would otherwise cause the individual to become ineligible for assistance.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2014*	17b-261m
Sec. 2	*July 1, 2014*	New section
Sec. 3	*July 1, 2014*	17a-476
Sec. 4	*July 1, 2014*	17a-22f
Sec. 5	*July 1, 2014*	17b-241a
Sec. 6	*July 1, 2014*	17b-245c
Sec. 7	*July 1, 2014*	17b-292
Sec. 8	*July 1, 2014*	17b-261(f)
Sec. 9	*July 1, 2014*	17b-261c

PRI *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 15 $	FY 16 $
Social Services, Dept.	GF - Cost	See Below	See Below

Municipal Impact: None

Explanation

The bill's provisions are not anticipated to result in a fiscal impact to the Department of Children and Family Services (DCF) or the Department of Mental Health and Addiction Services (DMHAS). The bill will result in a fiscal impact to the Department of Social Services (DSS). In summary:

- Sections 1, and 3 through 5 may result in a savings to the state Medicaid program. A 1% reduction in annual emergency department expenditures is approximately $2.3 million. The actual amount of savings will depend on the extent to which the administrative services organization (ASO) is able to achieve savings beyond what is assumed in their contract, or for which intensive case management (ICM) has already achieved, see below for additional information.

- Section 2 does not result in a fiscal impact to DSS to include the name of a client's primary care physician on their Medicaid identification card.

- Section 6 will result in an indeterminate impact to the DSS, see below for additional information.

- Section 7 will result in a cost of up to $9.8 million to DSS to provide continuous eligibility for children in the HUSKY program, see below for additional detail.

- Sections 8 and 9 will result in a per capita cost of between $294 to $2,116 for each month a Medicaid client is enrolled longer than they otherwise would be under the current policy, see below for additional detail.

Additional Information:

Sections 1, and 3 through 5 require the DSS, DMHAS and DCF, through their contract with their administrative services organizations (ASO), to provide intensive case management (ICM) services to Medicaid clients, including those with behavioral health needs. ICM is already being utilized in the Medicaid population. To the extent that this bill results in additional clients being served by ICM or results in an impact on the mix of services being utilized by Medicaid clients, there may be savings to the state. As previously stated, a 1% reduction in total annual emergency department expenditures will result in a $2.3 million savings. The ASO ICM services in the bill are targeted at all Medicaid clients who might benefit from ICM, but particularly high utilizers of emergency departments. The bill requires various reporting and assessment requirements of the ASO which are not anticipated to result in a cost to the state Medicaid program.

Section 6 requires the DSS to establish a telemedicine demonstration project at a federally qualified health center by January 1, 2015 and report the degree to which the project should be expanded to other regions by July 1, 2015. There may be a fiscal impact to DSS for providing coverage for telemedicine under Medicaid, which is uncertain. The state's Medicaid program does not currently provide telemedicine services or have a telemedicine reimbursement policy. The impact will depend on 1) the extent to which Medicaid clients utilize telemedicine services and the cost differential between telemedicine and in-person services, 2) the impact of telemedicine on total overall utilization of services covered by Medicaid, and 3) client

outcomes. [1]

Various case studies have suggested net health care savings from telemonitoring; primarily resulting from reduced hospital readmission, particularly for individuals with chronic diseases. It is important to note, it is uncertain from the following case studies what the upfront technology and personnel costs were and the time lag before a return on investment was realized through a reduction in overall health care costs.

Case 1: The Partners HealthCare program out of the Center for Connected Health did a study on their telehealth/telemonitoring program for individuals with cardiac disease and reported net savings over a seven year period of approximately $10 million for 1,265 patients (net savings per patient of $8,155).[2] The Partners' program savings were for participants predominately enrolled in public programs (e.g. Medicare, Medicaid and the state's safety net program).

Case 2: The Veterans Health Administration (VHA) started its telehealth program as a multisite pilot program and as of 2010 had over 300,000 lives in its Care Coordination/Home Telehealth Program.[3] The VHA reported cumulative net benefits of $3 billion since the program's inception in 1990. Savings are attributable to a reduction in redundant services and improved quality and health outcomes. The VHA program provides biometric information to remote monitoring care coordinators for individuals with various conditions, including heart failure, diabetes and Post Traumatic Stress Disorder (PTSD). The VHA reports annual costs per patient of $1,600.

Section 7 of the bill requires that children enrolled in the HUSKY

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[1] The State Innovation Model (SIM), which includes the state Medicaid program, is reviewing telemedicine.

[2] *Source*: Broderick, A., (2013). *Partners HealthCare: Connecting Heart Failure Patients to Providers Through Remote Monitoring*. Case Studies in Telehealth and Adoption; The Commonwealth Fund.

[3] *Source*: Broderick, A., (2013). *The Veterans Health Administration: Taking Home Telehealth to Scale Nationally*. Case Studies in Telehealth and Adoption; The Commonwealth Fund.

program remain continuously eligible for services for a period of not less than twelve months, which is expected to result in annual costs of up to $9.8 million.

In 2012, 86.5% of the children who were enrolled in the HUSKY program in January were still enrolled in the program at the end of the year, indicating that approximately 1.3% disenrolled per month.[4] Approximately one-third of these are assumed to have disenrolled due to aging out of the program. It is further assumed that an additional one-third of these children would have disenrolled due to other factors unchanged by continuous eligibility, e.g. moving out of state, transitioning to private insurance, etc.. Therefore, based on a total enrollment of 290,000, approximately 1,200 children each month who would have otherwise lost coverage will maintain eligibility under the terms of the bill. Assuming an average of a three-month gap in coverage[5] and an annual cost of $3,339 per child, increased Medicaid and HUSKY B costs of $9.8 million would result.

Lastly, **Sections 8 and 9** of the bill require that adults enrolled in the Medicaid program remain continuously eligible for services for a period of not less than twelve months, which is expected to result in a per capita cost of between $294 to $2,116 for each month the client is enrolled longer than they otherwise would be under the current policy. Data similar to that for children was not available for the adult population, which currently serves approximately 360,631 clients.

It should be noted that the Commissioner of the DSS testified that it is the Department's intent to delay the processing of Medicaid renewals for most HUSKY A and B households until 2015, and to move to a passive renewal process after that time. If this policy is implemented as intended, it is likely that most of the disenrollments assumed above for children will not occur, thereby reducing or eliminating most of the costs of a statutory continuous eligibility

[4] Council on Medicaid Assistance Program Oversight

[5] Median gap in coverage for six state study, *Enrollment and Disenrollment in MassHealth and Commonwealth Care*, Massachusetts Medicaid Policy Institute, 2010

policy. The same is assumed to be true for HUSKY C and D population. In addition, the Centers for Medicaid and Medicare Services have reported a push towards continuous eligibility at the federal level. [6]

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

[6] Source: *Hospital and Emergency Department Use and Its Impact on the State Medicaid Budget*, 2014. Legislative Program Review and Investigations Committee.

OLR Bill Analysis

sHB 5378

AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING MEDICAID-FUNDED EMERGENCY DEPARTMENT VISITS.

SUMMARY:

The departments of Social Services (DSS), Children and Families (DCF), and Mental Health and Addiction Services (DMHAS) contract with administrative service organizations (ASOs) to administer and manage the medical and behavioral health services provided to Medicaid recipients. This bill requires these ASOs to also provide intensive case management services that, among other things, (1) identify emergency departments with high numbers of Medicaid clients who frequently use them, and (2) create regional intensive case management teams to work with emergency department doctors.

The bill also requires these ASOs to (1) assess medical and behavioral health providers on certain criteria including ease of access and (2) perform outreach to Medicaid clients to encourage their use of these providers.

The bill requires children eligible for HUSKY A and B to remain eligible for at least 12 months, with certain exceptions. It also directs DSS to seek federal approval for a similar provision that would allow 12-month continuous eligibility for adults eligible for Medicaid. Current law allows changes in circumstances to cause enrollees to become ineligible for HUSKY A and B services within the first year of coverage.

The bill also requires DSS to establish a demonstration project to offer telemedicine, telehealth, or both as services covered by Medicaid

through federally qualified health centers, and report on whether this project should be expanded. Current law allows, rather than requires, DSS to establish such a project to provide telemedicine services.

Finally, the bill requires state-issued Medicaid benefits cards to include the name and contact information for the Medicaid beneficiary's primary care provider, if he or she has chosen one.

EFFECTIVE DATE: July 1, 2014

INTENSIVE CASE MANAGEMENT

Contract Requirements

The bill requires certain DSS, DCF, and DMHAS contracts with ASOs to provide for intensive case management services. This requirement applies to (1) DSS contracts with ASOs providing care coordination and other services for Medicaid and HUSKY A and B, (2) DMHAS contracts with ASOs managing mental and behavioral health services, and (3) DSS, DCF, and DMHAS (i.e., the Connecticut Behavioral Health Partnership) contracts with ASOs managing behavioral health services. Current law allows, but does not require, DSS to include intensive case management services in its Medicaid and HUSKY contracts with ASOs.

Definition and Scope of Intensive Case Management

Under the bill, the intensive case management services provided by the ASOs must (1) based on their numbers of frequent users (i.e., more than 10 annual visits), identify hospital emergency departments that may benefit from the provision of intensive case management services to those users; (2) create regional intensive case management teams that work with doctors to (a) identify Medicaid clients who may benefit from intensive case management, (b) create care plans for them, and (c) monitor their progress; and (3) assign at least one team member to each participating hospital emergency department during times of heavy emergency department use when Medicaid clients who are frequent users visit most.

The bill directs the agencies to submit their eligible expenditures for

intensive case management for reimbursement to the Centers for Medicare and Medicaid Services (CMS).

ASO Assessments

The bill requires ASOs in contracts with DSS to assess primary care providers and specialists and those in contracts with the Connecticut Behavioral Health Partnership to assess behavioral health providers and specialists. The assessments must determine how easily Medicaid patients may access provider or specialist services by considering waiting times for appointments and whether a provider is accepting new Medicaid clients. ASOs must also perform outreach to Medicaid clients to (1) inform them of the advantages of receiving care from these providers, (2) help connect clients with providers as soon as they are enrolled in Medicaid, and (3) help arrange visits with providers for frequent users within 14 days of an emergency department visit.

Reporting Requirements

The bill requires ASOs that (1) contract with DSS to provide care coordination for Medicaid and HUSKY and (2) have access to complete client claim adjudicated history, to report annually, by February 1, to DSS and the Council on Medical Assistance Program Oversight. The report must include the number of unduplicated Medicaid clients visiting an emergency department and, for those clients with 10 or more annual visits to any hospital:

1. the number of visits grouped into DSS-determined ranges,
2. the time and day of the visit,
3. the reason for the visit,
4. if the client has a primary care provider,
5. if the client had an appointment with the community provider within 14 days after the date of the emergency department visit, and
6. the cost to the hospital and the state Medicaid program of the

client's visit.

The DSS commissioner must use these annual reports to monitor the ASOs' performance. Performance measures must include whether the ASO helps Medicaid clients who are frequent users of emergency departments arrange visits to primary care providers within 14 days after an emergency department visit. The bill requires DSS to monitor reporting requirements for ASOs to ensure reports are completed and disseminated as required.

CONTINUOUS ELIGIBILITY

The bill requires children eligible for HUSKY A and B to remain eligible for at least 12 months unless, during that time, they reach age 19 or move outside of Connecticut. This Medicaid program option, known as "continuous enrollment," allows the enrollees to receive ongoing assistance for 12 months even if the parent's or caretaker's financial circumstances change during that time. Connecticut does not currently participate in this option, and as a result, changes in circumstances may cause families to become ineligible for HUSKY A and B services within the first year of coverage.

Federal law requires families receiving services to report any changes in circumstances that may affect eligibility between eligibility reviews. During a period of continuous enrollment, the family must comply with federal requirements for reporting information to DSS, such as a change of address.

TELEHEALTH AND TELEMONITORING

Current law allows DSS to establish a demonstration project to offer telemedicine as a Medicaid-covered service at federally qualified health centers. It defines "telemedicine" as using interactive audio, interactive video, or interactive data communication in the delivery of medical advice, diagnosis, care, or treatment. The definition excludes the use of fax or audio-only telephone.

The bill instead requires DSS to establish such a project by January 1, 2015, and permits the project to provide telemedicine, telehealth, or

both. This bill defines "telehealth" and "telemonitoring" as using telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across distance. Telehealth includes use of telephones, fax machines, e-mail systems, and remote patient monitoring devices used to collect and transmit patient data.

By July 1, 2015, DSS must submit a report on the demonstration project to the Appropriations and Human Services committees. The report must include the services offered, the cost-effectiveness of the program, and whether the program should be extended to other areas of the state (presumably, areas other than where the demonstration project takes place).

BACKGROUND

Related Bills

HB 5137, favorably reported by the Human Services Committee, requires children determined eligible for benefits under HUSKY A or B to remain eligible for at least 12 months, unless, during that time, the child reaches age 19 or moves out of Connecticut.

HB 5445, favorably reported by the Human Services Committee, extends Medicaid coverage for telemonitoring services as part of an integrated plan of care signed by a treating physician. The services must be provided by home health care agencies licensed in the state.

COMMITTEE ACTION

Program Review and Investigations Committee

Joint Favorable Substitute
Yea 11 Nay 0 (03/13/2014)